AMERICAN ACADEMY OF NEUROLOGY

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Chairman Fred Upton
Ranking Member Henry Waxman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Ranking Member Waxman:

The American Academy of Neurology (AAN), representing more than 24,000 neurologists and neuroscience professionals, is pleased to submit comments in response to the House Energy and Commerce Committees request for proposals to replace the current Medicare sustainable growth rate (SGR) formula.

Neurologists provide better quality care to patients with neurological disorders like dementia, Parkinson's, epilepsy, stroke, and migraine than other physicians. Where studied, care by a neurologist reduced costs and improved outcomes. Patients who receive care from neurologists often are discharged earlier from the hospital, receive more accurate diagnoses, and receive fewer unnecessary tests and procedures. For example, stroke patients have a lower mortality rate, and less disability when treated by a neurologist.

The Academy believes that without fundamental changes in payment policy, patient care will suffer, particularly for those with neurologic disease. Current policy has made cognitive specialties like neurology less attractive, leading to physician workforce shortfalls to treat this population, largely due to the economic pressure to emphasize procedures over direct patient care.

What is needed is a complete revision of the Medicare fee schedule, narrowing the payment gap between evaluation and management services and procedures.

Although the gap in median income between primary care physicians and specialists is well publicized, a recent review Medicare data demonstrates that the disparity is actually between procedural vs. non-procedural physicians. Health care policy discussions focused on this gap currently pit primary care physicians against all specialists. However, a number of specialists are also nonprocedural in that they derive the bulk of their income from evaluation and management. Nonprocedural specialties like neurology are experiencing the same economic disadvantages as primary care, with the resulting difficulty in attracting graduating US medical students into the specialty.

The Affordable Care Act (ACA), however, treats specialists as a monolithic group, ignoring the fact that several specialties spend the majority of their time in face-to-face patient care. The concept of primary care versus all specialties combined is both overly simplistic and inaccurate. The true dichotomy is between primary care and nonprocedural specialties taken together versus the procedural specialties. With this change in perspective, the current income gap has little medical rationale, and furthermore has unfortunate consequences on the quality and equitable allocation of patient care. This has led to misaligned financial incentives, leading to a procedure-centered instead of a patient-centered health care system.

We believe that steps could be taken to assure the availability of a balanced physician workforce, the availability of a full spectrum of expertise, and access of patients with chronic conditions to the appropriate physician. These solutions focus less on costly procedures and more on face-to face cognitive care that would provide higher quality, more appropriate care at lower cost to both Medicare and patients.

With the elimination of the consult codes in 2010 by CMS and lack of inclusion in the primary care incentive for 2011 and beyond, cognitive specialists like neurologists are now reimbursed less than primary care physicians for treating the same patients. Immediate steps are needed to ensure that the cognitive care work force remains viable in the near future.

Congress should immediately:

- Include specialists who routinely coordinate care and meet the 60% threshold for the primary care incentive as eligible.
- Reinstate payment for the consult codes eliminated by CMS starting in 2010.

Long-term shifts that move care from procedural to non-procedural care are essential for the long-term benefit of the Medicare program.

The current Medicare fee schedule is flawed in large part due to inherent biases that favor procedures and imaging services. These biases persist in spite of data showing inequity of provider reimbursement and the rapid growth of these services without a corresponding increase in medical need. Though recent legislation has been introduced to attempt to correct these biases by focusing on reform of the American Medical Association's Relative Value Update Committee (RUC), the Academy believes this approach will ultimately fall short of providing any basis for meaningful change. The problems associated with the devaluation of primary care services has more to do with the lack of goals put forth by CMS than with shortcoming of the RUC process. A more effective approach would be for Congress to give specific guidance to CMS to use RBRVS to create a new fee schedule that would favor primary and cognitive specialty care. Correction of the current undervaluation of primary care and cognitive physician work intensity would be one way to achieve this.

For the longer term Congress should:

- Change the misaligned financial incentives and close the income gap for both primary care and nonprocedural specialties.

- Support research to identify physician intensity of services to better show the parity of work from both procedural and non-procedural specialties.
- Pass meaningful malpractice reform that ensures that care provided by physicians is not subject to pressures that drive the use of high cost defensive medicine.
- Explore alternatives to the SGR such as:
    - Replace the SGR model which holds all providers accountable to the same target with one where services are grouped by service categories and held to separate growth targets. Categories should be based on service (not specialty) such as: primary care; cognitive specialty care (or other E/M); imaging and tests; major procedures; minor procedures; and anesthesia.
    - Support mechanisms for growth target (or SGR) exemptions for providers participating in alternative quality-based models such as accountable care organizations or patient-centered medical homes.
    - Cut the conversion factor to allow for substantial bonuses for primary care and other critical cognitive care specialties like neurology, rheumatology, and infectious disease.
    - Pay all physicians based on time, removing incentives to spend inadequate time with patients, read images too quickly, or focus on procedures that may be of marginal utility. This model would return the practice of medicine to a truly patient-centered focus by freeing physicians to meet their patients' needs. This model would allow reimbursement for the time physicians spend doing paperwork, telehealth activities, and more extensive care coordination. Providing more targeted care would likely decrease health care utilization, improve outcomes, and increase patient satisfaction. Hourly rates would still need to distinguish by service provided, however, these rates could be defined in terms of patient value instead of the relative value structure used in the current Medicare FFS model.

It is clear that these changes will not be welcomed by all physician groups, but in order to control costs and ensure an appropriate mix of physicians for all Medicare beneficiaries, fundamental changes in the health care delivery system must occur.

Sincerely,

Bruce Sigsbee, MD, FAAN
President, American Academy of Neurology